WVDNR
West Virginia Division of Natural Resources

For Official Use Only

Issued By:_____Date: _____

Class Y Permit No. _____

WEST VIRGINIA DIVISION OF NATURAL RESOURCES
APPLICATION FOR A CLASS Y CROSSBOW PERMIT

(Application must be submitted within six months of Physician/APRN/PA's certification)

The Class Y Crossbow Permit must be accompanied by a valid hunting license and any stamps necessary to participate in the designated season unless the permit holder is exempt from those license requirements. The Class Y Permit is authorization to hunt with a crossbow and only applies to the taking of game species during established archery and firearms seasons. You are required to carry the Class Y Permit with you while exercising this privilege and must present it to any law enforcement officer upon request.

- **This application must be completed in full. An incomplete application will not be considered for a Class Y crossbow permit.**

For the purpose of securing authorization to hunt with a crossbow, I attest that I have a permanent and substantial physical impairment which renders me so disabled as to be unable to use a conventional bow and arrow device.

The following is my true description:

Name (please print): _____Email:_____

Date of Birth: _____ Social Security Number: _____ Telephone: _____

Driver's License Number: _____ State: _____ Expiration Date: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Address: _____
(Street, PO Box, Route) City State Zip County

Applicant Signature: _____ Date: _____

Class Q Permit Holders

Do you hold a Class Q Permit? Yes ☐ No ☐ Current Class Q Permit Number: _____

If yes, disregard the remainder of this application and submit it to the address listed at the bottom of this form.

Send completed application with original signatures to:
West Virginia Division of Natural Resources
ATTN: License Section
324 Fourth Avenue
South Charleston WV 25303-1228

THE FOLLOWING IS TO BE COMPLETED BY A LICENSED PHYSICIAN/APRN/PA:

Please print or stamp clearly. If not legible, the application will not be accepted.

Physician/APRN/PA/ Name: _____

Address: _____
(Street, PO Box, or Route) *City* *State* *Zip*

Title: _____Telephone: _____ Fax: _____

1. **After administering the pinch, grip and nine-hole peg tests on _____, 20____, it is my opinion that: [Check One]**

❒ the applicant has a **PERMANENT AND SUBSTANTIAL** loss of function in one or both hands while **FAILING** to meet the minimum standards of the upper extremity pinch, grip, and nine-hole peg tests;

❒ the applicant **DOES NOT** have a permanent or substantial loss of function in one or both hands and **DOES NOT** fail to meet the minimum standards of the upper extremity pinch, grip, and nine-hole peg tests.

2. **After administering the shoulder strength test on _____, 20____, it is my opinion that: [Check One]**

❒ the applicant has a **PERMANENT AND SUBSTANTIAL** loss of function in one or both shoulders while **FAILING** to meet the minimum standards of the shoulder strength test;

❒ the applicant **DOES NOT** have a permanent or substantial loss of function in one or both shoulders and **DOES NOT** fail to meet the minimum standards of the shoulder strength test.

Pursuant to results obtained from administration of the pinch, grip and nine-hole peg tests and/or the shoulder strength test, **I do hereby swear and affirm, under penalty of law, that I have personally examined the above named individual, and that the information herein is true and accurate to the best of my knowledge.**

_____ _____
Physician/APRN/PA/Signature Date

_____
Print Physician/APRN/PA/ License Number and State of Issue

_____ _____
Applicant Signature Date

_____
Print Applicant Name

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ATTN: License Section
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South Charleston WV 25303-1228